HANCOCK COUNTY FAMILY & CHILDREN FIRST COUNCIL REFERRAL

A. REFERRAL INFORMATION

Date of Referral:	Agency/Relationship to Youth:
Name of Person Making Referral:	Phone Number:
Address:	City:
State:	Zip Code:

Type of Referral:
☐ Service Coordination ☐ Wraparound

B. CHILD/ YOUTH DEMOGRAPHICS

Name of Youth:	Date of Birth:
Gender: ☐ Male ☐ Female ☐ Transgender	Race/Ethnicity:
Currently Living with: (Name)	Relationship to child:
Address:	City/State/Zip Code:
Phone:	Alternate Phone:
Caregiver #1 Employer (Business, Address, Phone):	Caregiver #2 Employer (Business, Address, Phone)
Who has Custody of Youth/Relationship to Youth:	Custodian Contact Information:
Who is Youth's Guardian/Relationship to Youth:	Guardian Contact Information:
Caregiver #1 Employer (Business, Address, Phone)	Caregiver # 2 Employer (Business, Address, Phone)
School District of Residence:	School District of Attendance:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:
Name Family Member/Close Friend to Youth/Family:	Relationship/Phone:

Describe Youth's/Family's Church Affiliation:

Primary Physician at Time of Intake? ☐ Yes ☐ No

If Yes:

Physician Name _____ Phone No._____

Address _____

Medicaid or Medicaid Managed Care Plan? If so, provider name _____

C. SERVICE COORDINATION INFORMATION

1. Who is the Service Coordinator (lead contact person for the youth/family)?

Name: Agency: Phone:

2. Best time/method to meet/reach youth/family?

3. What is youth's/family's preferred meeting place?

4. What agencies are currently involved with the youth/family? Please check all that apply.

Name of Agency	Contact Person	Date of Last Appointment
☐ HC Child Protective Services		
☐ Family Resource Center		
☐ Other Mental Health Provider:		
☐ Hancock County Board of DD (BVC)		
☐ Probation/Parole/Juvenile Court		
☐ HC Family Court with this program		
☐ School (IEP/504/GRADS/Counseling)		
☐ HC DJFS (SSI, Food Stamps, Medicaid)		
☐ County/City Health Dept.		
☐ HMG/Early Intervention		
☐ HMG/Home Visiting		
☐ WIC		
☐ Metro Housing		
☐ Psych./Hospitalization		
☐ CASA		
☐ Keeping Kids Safe		
☐ Other:		
☐ Other:		
☐ Other:		

D. PRESENTING NEEDS

1. Briefly describe the presenting issue or areas of need (include length of time the issue has been occurring).

2. Explain what community resources have been exhausted to ensure least restrictive service implementation. Please indicate what services have been provided and by what agencies. Also indicate what financial resources have been exhausted to provide services/needed items.

Community: **Financial:**

3. What barriers have the youth/family encountered that has prevented previous/current services to not be successful?

4. Identify the end goal or mission of the Youth/Family and agencies involved (this must be a measurable goal).

5. Does the Youth/Family feel they will be able to fulfill the necessary commitments to achieve the end goal or mission? Why or why not? If not, what can we do to help them make this commitment?

I participated in the referral process, agree with it and the information provided therein, and understand my family's commitment.

_____ _____

Parent/Guardian Signature **Date**

FCFC USE ONLY

Person receiving referral:	Date:
Risk Assessment Score: _____ Are IHBT services being provided? ☐ Yes *(if yes, not eligible for WRAP)* ☐ No	Did youth score any "3" ☐ Yes ☐ No If yes date of meeting:
Outcome of referral: ☐ Information & Referral ☐ Service Coordination ☐ Wraparound	
Service Provider/Agency Assigned Case:	Date:
FCFC Coordinator Signature:	Date:

Hancock County Family and Children First Council
Cross System Risk Screen Tool

Family Name:	Date:
Child Name:	D.O.B.:
Service Coordinator: (Lead worker/contact):	Agency:

Known Presenting Risks to Child/Youth (in last 30 days unless specified):

☐ Suicidal Ideation, Gestures, Attempts (3 pts)	☐ Violent Behaviors (toward Others, Animals, Property) (3 pts)	☐ Chargeable for Sex Offense (3 pts)
☐ Self-Injurious Behavior (2 pts)	☐ Hears Voices/Sees Things (2 pts)	☐ Fire Setting Current or History (2 pts)
☐ Acute Family Crisis or Conflict (2 pts)	☐ Victimization: Physical, Emotional, or Sexual – Current or History (2 pts)	☐ Verbal/Written Threats to Others (2 pts)
☐ Runaway-Current (3 pts) or History (1 pt)	☐ Youth's/Family's Lack of Stable Residence/ Homelessness (2 pts)	☐ Suspected Abuse in Current Placement (2 pts)
☐ Availability of Weapons (2 pts)	☐ Parent w/Severe Chronic Illness (2 pts) Identify:	☐ Parent w/Drug or Alcohol Problem (2 pts)
☐ Aggressive Behaviors (toward Others, Animals, Property) (1 pt)	☐ Sexual Acting Out/ Impulsivity-Current (2 pts) or within Last Year (1 pt)	☐ Parent w/Chronic/Acute Mental Illness, Dev. Delay, MR (2 pts)
☐ Resides in High Crime Neighborhood (1 pt)	☐ Drug/Alcohol Use (1 pt)	☐ Lack of Caregiver Supervision and/or Monitoring (1 pt)
☐ Suspended, Expelled, Dropped out of School (1 pt)	☐ Negative Peer Involvement and/or Gang Activity (1pt)	☐ Anorexia/Bulimia (1 pt)
☐ Known/Suspected Criminal Activity (1 pt)	☐ Prejudicial Thinking/ Ideation (1 pt)	☐ Truancy (1 pt)
☐ Unrestricted Internet Access (1 pt)	☐ Impulsive Behavior (1 pt)	☐ Limited Ability to Control Anger (1 pt)
☐ Depression – Current or History (1 pt)	☐ Held Back/Behind in Grade Level within Last 2 Years (1 pt)	☐ IEP or 504 Plan in Place? (1 pt)
☐ Youth with Severe Chronic Illness (1pt) Identify:	☐ Youth with Chronic/Acute Mental Illness, Dev. Delay, MR (1 pt)	☐ Difficulty Accepting Supervision/Instruction (1 pt)
		☐ Other (describe) (1 pt)
Total Score:	Completed By:	

Information Source:	Relationship to Child/Youth:

Risk Screen Interpretation

Score of:	Results in following action:
Any 3 pt. item	An Emergency Service Coordination meeting will be held w/in 48 hours. Triage Representative will ensure a meeting occurs.
18+	Level #3 WRAP Facilitator is assigned (if openings are available) when informal case is requesting more support (2-system involvement required)
12-17	Level #2 Service Coordination. Service Coordinator will facilitate family team meetings/service coordination.
1 – 11	Level #1 Information & Referral Family will be linked up with existing services. A Service Coordination team is not indicated Individual will take normal action per their agency to continue providing services for the child, youth, and/or family.

Youth can be rescored at any time, but at least every 6 months.

HANCOCK COUNTY FAMILY FIRST COUNCIL
AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Youth Name: _____ Date of Birth _____

I give my permission for the following agencies/organizations through their designated representatives to exchange information regarding case history and treatment goals of the above-named youth in order to develop an Individualized Family Service Coordination Plan.

ADAMHS Board	HC Sheriff's Department
Family Resource Center	Hancock Public Health
Electronic Health Record	Hope House
Findlay City Schools	Medicaid Provider _____
Findlay Police Department	NAMI
Habitat for Humanity	Ohio Dept. of Youth Services
HC Board of Developmental Disabilities	Open Arms
HC Educational Service Center	Opportunities for Ohioans with Disabilities
HC Family and Children First Council	Parent Advocacy Connection
HC Job & Family Services/Children's Protective Services	Physician _____
HC School _____	Other _____
HC Juvenile Court	Other _____

I UNDERSTAND THE INFORMATION ABOUT ME AND MY CHILD, WHEN UNDER SUBPOENA, WILL BE REQUIRED TO BE RELEASED WITH OR WITHOUT MY SIGNED CONSENT.

PURPOSE OF NEED FOR DISCLOSURE: This person is voluntarily participating in a comprehensive service program. Representatives of the above agencies/organizations may be involved in formulating and carrying out the Individualized Family Service Coordination Plan.
SPECIFIC INFORMATION TO BE DISCLOSED: Treatment plan, treatment goals, history, test results (physical, psychiatric, psychological), medications, clinical impressions, obstacles to treatment, comprehensive reunification plan, school/education records, and _____.

NOTE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

ELECTRONIC HEALTH INFORMATION FILES: I also consent to allow the entry of the above-named youth's personal health information to be entered into a protected cloud-based Electronic Protected (EPHI) file. The electronic health record data system follows all requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to ensure the confidentiality, integrity, and availability of EPHI, and to mitigate any reasonable risks or hazards to EPHI. Further, the electronic health record data system protects against all unauthorized disclosures and manages compliance for all employees, contractors, and vendors.

I hereby release the Hancock County Family and Children First Council from all legal responsibility or liability that may arise from this authorization.

I have read and fully understand the content of this form. The authorization may be revoked at any time, except to the extent that action has been taken in reliance thereon, by the notification of the Hancock County Family and Children First Council of my intention to do so. This authorization (unless expressly revoked earlier) expires itself upon termination of the case.

_____ / _____ _____
Signature of client/parent/authorized person **`Relationship** **Date**

_____ / _____ _____
Signature of client/parent/authorized person **Relationship** **Date**

_____ _____
***Witness** **Date**

This consent revoked by: _____ **On** _____

Revised 10/20/2020